Important note
Even though this policy may indicate that a particular service or supply may be considered covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Senior Care members, this policy will apply unless Medicare policies extend coverage beyond this Medical Policy & Criteria Statement. Senior Care policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website.

SERVICE: Chiropractic Services

PRIOR AUTHORIZATION: Required for commercial lines of business.

POLICY:

Note: SWHP coverage of chiropractic care depends on the contract benefit language. Many contracts do not cover this service.

For coverage of chiropractic care, objective evidence of subluxation is required.

- This requires either an X-ray OR a physical exam with required components
  To demonstrate a subluxation based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required:
  1. Pain/tenderness evaluated in terms of location, quality, and intensity;
  2. Asymmetry/misalignment identified on a sectional or segmental level;
  3. Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility);
  4. Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament.


Exclusions:

- Continuing chiropractic care AFTER maximum therapeutic benefit, is considered not medically necessary.
- Chiropractic care for asymptomatic persons or persons without identifiable clinical condition is considered not medically necessary.
- Continuing chiropractic care when the condition is neither improving nor worsening is considered not medically necessary.
- Manipulation is not covered and is unproven for non-neuromusculoskeletal conditions (e.g., attention-deficit hyperactivity disorder, dysmenorrhea, epilepsy; gastro-intestinal disorders, and scoliosis: not an all-inclusive list).

Treatment quantity limit:

Medicare products limits:
• Up to 12 chiropractic manipulation treatments per calendar month.
• Maximum of 12 to 30 chiropractic manipulation treatments per calendar year, depending on the diagnosis (see Novitas LCD L34816 for list of diagnoses and limits).

Commercial product limits:
• Up to 5 chiropractic manipulation treatments per calendar month.
• If the “Evidence of Coverage” document does not specify an annual limit for chiropractic treatments per calendar year, then this benefit is limited to no more than 30 chiropractic manipulation treatments per calendar year.

CODES:

Important note:
CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes: 98940, 98941 and 98942 with AT modifier

CMS: LCD L34816 Chiropractic Services

POLICY HISTORY:

<table>
<thead>
<tr>
<th>Status</th>
<th>Date</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>New</td>
<td>5/28/2015</td>
<td>New policy</td>
</tr>
</tbody>
</table>

REFERENCES:
The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy.


MEDICAL COVERAGE POLICY

SERVICE: Chiropractic Services

Policy Number: 214
Effective Date: 6/19/2015
Last Review: 5/28/2015
Next Review Date: 5/28/2016

Appendix

CMS ICD-9 covered coded

**Group 1 Codes**

739.0 NONALLOPATHIC LESIONS OF HEAD REGION NOT ELSEWHERE CLASSIFIED
739.1 NONALLOPATHIC LESIONS OF CERVICAL REGION NOT ELSEWHERE CLASSIFIED
739.2 NONALLOPATHIC LESIONS OF THORACIC REGION NOT ELSEWHERE CLASSIFIED
739.3 NONALLOPATHIC LESIONS OF LUMBAR REGION NOT ELSEWHERE CLASSIFIED
739.4 NONALLOPATHIC LESIONS OF SACRAL REGION NOT ELSEWHERE CLASSIFIED
739.5 NONALLOPATHIC LESIONS OF PELVIC REGION NOT ELSEWHERE CLASSIFIED

**Group 2 Paragraph : Secondary Diagnosis Codes**

**Group A Diagnoses**

Covered for:

**Group 2 Codes**

307.81 TENSION HEADACHE
719.48* PAIN IN JOINT INVOLVING OTHER SPECIFIED SITES
    When using 719.48, you must specify spine as the site.
723.1 CERVICALGIA
724.1 PAIN IN THORACIC SPINE
724.2 LUMBAGO
724.5 BACKACHE UNSPECIFIED
724.8 OTHER SYMPTOMS REFERABLE TO BACK
728.85 SPASM OF MUSCLE
784.0 HEADACHE

**Group 3 Paragraph :**

**Group B Diagnoses**

Covered for:

**Group 3 Codes**

720.1 SPINAL ENTHESOPATHY
721.0 CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.1 CERVICAL SPONDYLOSIS WITH MYELOPATHY
721.2 THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.6 ANKYLOSING VERTEBRAL HYPEROSTOSIS
721.90 SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MYELOPATHY
721.91 SPONDYLOSIS OF UNSPECIFIED SITE WITH MYELOPATHY
724.79 OTHER DISORDERS OF COCCYX
729.1 MYALGIA AND MYOSITIS UNSPECIFIED
729.4 FASCITIS UNSPECIFIED
846.0 LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN
846.1 SACROILIAC (LIGAMENT) SPRAIN
846.2 SACROSPINATUS (LIGAMENT) SPRAIN
846.3 SACROTUBEROUS (LIGAMENT) SPRAIN
846.8 OTHER SPECIFIED SITES OF SACROILIAC REGION SPRAIN
847.0 NECK SPRAIN
847.1 THORACIC SPRAIN
847.2 LUMBAR SPRAIN
847.3 SPRAIN OF SACRUM
847.4 SPRAIN OF COCCYX

**Group 4 Paragraph :**

**Group C Diagnoses**

Covered for:

**Group 4 Codes**
353.0 BRACHIAL PLEXUS LESIONS
353.1 LUMBOSACRAL PLEXUS LESIONS
353.2 CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3 THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4 LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.8 OTHER NERVE ROOT AND PLEXUS DISORDERS
722.91 OTHER AND UNSPECIFIED DISC DISORDER OF CERVICAL REGION
722.92 OTHER AND UNSPECIFIED DISC DISORDER OF THORACIC REGION
722.93 OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION
723.0 SPINAL STENOSIS IN CERVICAL REGION
723.2 CERVICOCRANIAL SYNDROME
723.3 CERVICOBRACHIAL SYNDROME (DIFFUSE)
723.4 BRACHIAL NEURITIS OR RADICULITIS NOS
723.5 TORTICOLLIS UNSPECIFIED

Group 5 Paragraph:
Group D Diagnoses
Covered for:
Group 5 Codes
721.3 LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.41 SPONDYLOSIS WITH MYELOPATHY THORACIC REGION
721.42 SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
721.7 TRAUMATIC SPONDYLOSIS
722.0 DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10 DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11 DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.4 DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51 DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
722.52 DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.6 DEGENERATION OF INTERVERTEBRAL DISC SITE UNSPECIFIED
722.81 POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82 POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83 POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
724.01 SPINAL STENOSIS OF THORACIC REGION
724.02 SPINAL STENOSIS, LUMBAR REGION, WITHOUT NEUROGENIC CLAUDICATION
724.03 SPINAL STENOSIS, LUMBAR REGION, WITH NEUROGENIC CLAUDICATION
724.3 SCIATICA
724.4 THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
724.6 DISORDERS OF SACRUM
738.4 ACQUIRED SPONDYLOLISTHESIS
756.11 CONGENITAL SPONDYLOLISTHESIS LUMBOSACRAL REGION
756.12 SPONDYLOLISTHESIS CONGENITAL
839.01 CLOSED DISLOCATION FIRST CERVICAL VERTEbra
839.02 CLOSED DISLOCATION SECOND CERVICAL VERTEbra
839.03 CLOSED DISLOCATION THIRD CERVICAL VERTEbra
839.04 CLOSED DISLOCATION FOURTH CERVICAL VERTEbra
839.05 CLOSED DISLOCATION FIFTH CERVICAL VERTEbra
839.06 CLOSED DISLOCATION SIXTH CERVICAL VERTEbra
839.07 CLOSED DISLOCATION SEVENTH CERVICAL VERTEbra
839.08 CLOSED DISLOCATION MULTIPLE CERVICAL VERTEbrae
839.20 CLOSED DISLOCATION LUMBAR VERTEbra
839.21 CLOSED DISLOCATION THORACIC VERTEbra
839.41 CLOSED DISLOCATION COCCYX
839.42 CLOSED DISLOCATION SACRUM
953.0 INJURY TO CERVICAL NERVE ROOT
953.1 INJURY TO DORSAL NERVE ROOT
953.2 INJURY TO LUMBAR NERVE ROOT
953.3 INJURY TO SACRAL NERVE ROOT
953.4 INJURY TO BRACHIAL PLEXUS
953.5 INJURY TO LUMBOSACRAL PLEXUS
953.8 INJURY TO MULTIPLE SITES OF NERVE ROOTS AND SPINAL PLEXUS